# CHAPTER II

# PROVIDER PARTICIPATION REQUIREMENTS

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# CHAPTER II
# PROVIDER PARTICIPATION REQUIREMENTS

## PARTICIPATING PROVIDER

A participating provider is an agency or program that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and that has a current signed participation agreement with DMAS.

## PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. The agency or individual interested in becoming a Medicaid provider must submit a request to DMAS requesting a provider participation agreement. Providers must sign a DMAS Participation Agreement (see "Exhibits" at the end of this chapter) for providing any of the services offered in the Individual and Family Developmental Disabilities Support (DD) Waiver and return it, with a copy of the required license, certification, or approval necessary to First Health Services – Provider Enrollment Unit.

First Health Services (First Health) is the contractor responsible for provider enrollment. First Health will review the documentation from the provider and verify the provider qualifications. If the provider meets the qualifications as outlined in this chapter, First Health will send the provider notification that the application has been approved. The provider must maintain documentation (including relevant license, vendor agreement, letter of approval, personnel records, etc.) that verifies the provider's qualifications for review by DMAS staff.

Upon receipt of the signed agreement and verification of approval, First Health returns a copy of the signed agreement to the provider and assigns a provider number. This number must be used on all claims and correspondence submitted to the Medicaid Program.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

## REQUESTS FOR PARTICIPATION

The DD Waiver offers many services in which providers are currently enrolled to provide as a Virginia Medicaid provider. If you are currently enrolled as a provider of personal care, (non-skilled) respite care, supported employment, day support, in-home residential services, crisis stabilization, therapeutic consultation, service facilitator for consumer directed services, skilled nursing, assistive technology or environmental modification services, and have an active provider identification number, you may use your existing Medicaid identification number to bill for services rendered to the DD Waiver population. Your provider number will automatically be assigned a specialty code that will allow you to bill for DD Waiver services using your existing provider identification number. All terms and conditions of your Medicaid Participation Agreement remain in effect. However, providers wanting to provide family/caregiver training services, Personal Emergency Response Services (PERS), or support coordination services must

obtain a separate provider identification number and cannot utilize an existing provider identification number to bill for these services provided to the DD Waiver population. Support Coordination providers cannot provide other waiver services to DD Waiver individuals.

To become a Medicaid provider of DD Waiver services, you must:

1. Request a participation agreement by writing, calling, or faxing the request to:

   First Health
   VMAP-PEU
   P.O. Box 26803
   Richmond, Virginia 23261-6803

   Call 804-270-5105 or 1-888-829-5373 (in state toll-free) or fax to 804-270-7027.

2. Forward a signed copy of the participation agreement with a copy of the required license, certification, or approval to:

   First Health
   VMAP-PEU
   P.O. Box 26803
   Richmond, Virginia 23261-6803

**PARTICIPATION REQUIREMENTS**

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their participation agreements. Providers approved for participation in the Medicaid Program must perform the following activities, as well as any others specified by DMAS:

- Immediately notify First Health Services, in writing, whenever there is a change in the information that the provider previously submitted to the First Health Enrollment/Certification Unit. For a change of address, notify First Health Services prior to the change and include the effective date of the change;

- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the individual's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C.§§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin;

- Provide services and supplies to individuals in full compliance with the Virginians

with Disabilities Act, (§§ 51.5-1 through 51.5-59 of the Code of Virginia), as amended;

- Comply with the Americans with Disabilities Act, as amended (42 U.S.C. §§ 12101 through 12213), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. However, if a third party payer reimburses $5.00 for an $8.00 charge and Medicaid reimburses $6.00, the provider may obtain the additional $1.00 from Medicaid;

- Providers may not bill DMAS or recipients for broken or missed appointments;

- Use Medicaid Program-designated billing forms for submission of charges;

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the care provided;

- In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least 5 years after such minor has reached the age of 18

years. (Refer to the section titled "Maintaining Records" in Chapter IV.);

- Furnish to authorized state and federal personnel, in the form and manner requested, access to individual records and facilities;

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of services to Medicaid individuals;

- Hold information regarding individuals confidential. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public, except as required by applicable law;

- Change of Ownership: When ownership of the provider changes, DMAS shall be notified at least 15 calendar days before the date of change;

- Suspected Abuse or Neglect: Pursuant to §§ 63.1-55.3 and 63.1-248.3 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local Department of Social Services (DSS) adult or child protective services worker and to DMAS;

- Adherence to provider contract and the DMAS Provider Manual: In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider contracts and in the DMAS Provider Manual.

**PROVIDER QUALIFICATIONS**

To qualify as a DMAS provider of selected DD Waiver services or Support Coordination, the provider of the services must meet the following criteria:

- The provider must demonstrate the financial solvency to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

- The provider must have the administrative and financial management capacity to meet state and federal requirements; and

- The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements.

Support Coordination

Providers must have a current DMAS Participation Agreement to provide Support Coordination services.

A provider or contract agency that provides Support Coordination services must employ individuals who possess a combination of developmental disability work experience and relevant education which indicates that he or she has the knowledge, skills, and abilities (KSAs), as established by DMAS, necessary to perform Support Coordination services billable under Medicaid.

The provider will certify every three years, via letter to First Health, that the individuals who provide Support Coordination services meet the required KSAs. Individuals who do not demonstrate or possess the required KSAs cannot provide Support Coordination services for which Medicaid reimbursement is received.

For Support Coordination services to qualify as reimbursable services under Medicaid reimbursement, the individual employed as a Support Coordinator must have, at entry level, qualifications that are documented or observable to include:

A. Knowledge of:

1. The definition, causes, and program philosophy of developmental disabilities;
2. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and consumer-directed (CD) service facilitation;
3. Different types of assessments, including functional assessment, and their uses in service planning;
4. Human rights;
5. Local community resources and service delivery systems, including support services (e.g., housing, financial, social welfare, dental, educational, transportation, communications, recreation, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g., churches, clubs, self-help groups);
6. Types of developmental disabilities programs and services;
7. Effective oral, written, and interpersonal communication principles and techniques;
8. General principles of record documentation; and
9. The service planning process and major components of a service plan.

B. Skills in:

1. Interviewing;
2. Negotiating with individuals and service providers;
3. Observing, recording, and reporting on an individual's behavior and functional level;
4. Identifying and documenting an individual's need for resources, services, and other supports;
5. Using information from assessments, evaluations, observation, and interviews to develop service plans;
6. Identifying services within the community and established service system to meet the individual's needs;
7. Formulating, writing, and implementing individualized service plans to promote goal attainment;
8. Coordinating the provision of services by diverse public and private providers;
9. Identifying community resources and organizations and coordinating resources and activities; and
10. Using assessment tools (e.g., level of functioning survey).

C. Ability to:

1. Be persistent and remain objective;
2. Work as a team member, maintaining effective inter- and intra-agency working relationships;
3. Demonstrate a positive regard for individuals and their families (e.g., treating recipients as individuals, allowing risk-taking, avoiding stereotyping of people with developmental disabilities, respecting individuals' and families' privacy, and believing individuals are valuable members of society);
4. Work independently performing position duties under general supervision;
5. Communicate effectively, verbally, and in writing; and
6. Establish and maintain ongoing supportive relationships.

Individuals and organizations providing Support Coordination services cannot be a direct service provider for any other DD Waiver service with the exception of CD Service Facilitation. An organization can be a Support Coordination provider and a CD Services Facilitation provider; however, one individual cannot provide both services to the same DD Waiver recipient. Support coordinators must also have back-up coverage available when the coordinator is absent due to illness, injury, or vacation.

Individuals may be employed by an organization that provides Support Coordination services to the support coordinator's spouse, child, or other persons for which the Support Coordinator is the legal guardian. The individual, however, may not be directly involved in the provision of Support Coordination Services to these persons.

The DD Waiver offers the following services: in-home residential support services, supported employment, respite care (agency and consumer-directed), environmental modifications, assistive technology, day support, prevocational services, therapeutic consultation, personal care (agency and consumer-directed), skilled nursing, family and caregiver training, Personal Emergency Response Systems (PERS), adult companion care, and crisis stabilization. Provider qualifications to provide these services are listed separately.

In-Home Residential Support

Providers must have a current DMAS Participation Agreement to provide In-Home Residential Support services. The agency or individual designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

In-Home Residential Support providers for adults (age 18 years and older) must meet one of the following provider categories:

1. An agency licensed by DMHMRSAS as a provider of Residential Services which may provide and bill for In-Home Residential Support services; or

2. An agency licensed by DMHMRSAS as a provider of Supportive Residential Services which may provide and bill for In-Home Residential Support services.

In-Home Residential Support providers for children (under age 18 years) must meet one of the following provider categories:

1. An agency licensed by DMHMRSAS as a provider of Supportive Residential Services which may provide and bill for In-Home Residential Supports; or

2. An agency licensed by DMHMRSAS with an Interdepartmental License (under the Consortium of Interdepartmental Regulations) that may provide and bill for In-Home Residential Supports.

Providers must also assure that persons providing In-Home Residential Support services have received training in the characteristics of developmental disabilities and appropriate interventions, training strategies, and other methods of supporting individuals with functional limitations.

Private agencies or a provider may employ or contract with individuals who meet the requirements to provide In-Home Residential Support, but the agency or provider must have a provider agreement with DMAS to provide In-Home Residential Support and bill for the services provided by those individuals.

In-Home Residential Support providers may be members of the individual's family, but may not be the parent of a minor child receiving services, the individual's spouse, or a legally responsible relative or legal guardian for the individual. Payment may not be made for services rendered by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who provide In-Home Residential Support services must meet the same standards as providers who are unrelated to the individual.

Day Support

Providers must have a current DMAS Participation Agreement to provide Day Support services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Day Support providers must be licensed by DMHMRSAS as a provider of Day Support services or have CARF certification as a day support program.

Providers must ensure and document that persons providing Day Support services have received training, within 30 days after beginning to provide DD Waiver services, in the characteristics of developmental disabilities and appropriate interventions, training strategies, and methods of supporting individuals with functional limitations.

Supported Employment

Providers must have a current DMAS Participation Agreement to provide Supported Employment services. The agency designated in the Participation Agreement is the only authorized service provider and must bill DMAS for Medicaid reimbursement.

Supported Employment providers must meet one of the following provider categories:

1. Vendor of extended employment services, long-term employment support services, or supported employment services for the Department of Rehabilitative Services; or

2. Programs certified by CARF to provide supported employment services.

Therapeutic Consultation

Providers must have a current DMAS Participation Agreement to provide Therapeutic Consultation services. An individual consultant with the necessary qualifications may obtain a DMAS Participation Agreement or be employed by or contracted with an agency with a Participation Agreement to provide the services. The individual or agency designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The following types of Therapeutic Consultation are reimbursable as DD Waiver services when the individual consultant or the employee of an agency with a valid Participation Agreement meets the required provider standard:

1. Psychology Consultation

   a. A Psychologist who is licensed by the Commonwealth of Virginia; or

   b. A Licensed Professional Counselor who is licensed by the Commonwealth of Virginia; or

   c. A Licensed Clinical Social Worker who is licensed by the Commonwealth of Virginia; or

   d. A Psychiatric Clinical Nurse Specialist who is licensed by the Commonwealth of Virginia; or

   e. A Psychiatrist who is licensed by the Commonwealth of Virginia.

2. Behavior Consultation

   a. A Psychologist who is licensed by the Commonwealth of Virginia; or

   b. A Licensed Professional Counselor who is licensed by the Commonwealth of Virginia; or

   c. A Licensed Clinical Social Worker who is licensed by the Commonwealth of Virginia.

3. Physical Therapy Consultation

   A Licensed Physical Therapist who is licensed by the Department of Health Professions.

4. Occupational Therapy Consultation

   A Registered Occupational Therapist who is registered and certified by the Department of Health Professions.

5. Speech Therapy Consultation

   A Licensed Speech Language Pathologist who is licensed by the Department of Health Professions.

6. Recreational Therapy Consultation

   A Certified Therapeutic Recreation Specialist with certification from the National Council for Therapeutic Recreation Certification.

7. Rehabilitation Engineering Consultation

   A Rehabilitation Engineer or certified rehabilitation specialist. The Therapeutic Consultation provider must also possess at least one year of documented work experience in developmental disabilities services, performing functional analyses of behavior, developing behavior support strategies, developing written behavior support plans, and training caregivers in the implementation of behavior support interventions.

Personal Care Services

Providers must have a current DMAS Participation Agreement to provide Personal Care services. DMAS-enrolled Personal Care agencies may provide DD Waiver Personal Care under that agreement. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement. DMAS will not contract directly with individuals to provide personal care services.

The following types of providers can deliver Personal Care Services:

1. Licensed by DMHMRSAS as a provider of Residential Services or Supportive Residential Services. These providers must employ a program (in home residential services) supervisor who will provide ongoing supervision of all personal assistants and conduct the initial assessment and subsequent reassessments; or

2. Personal Care/Respite Care providers who have a participation agreement with DMAS. These providers (does not apply to DMHMRSAS-licensed agencies) must:

   a. Employ or subcontract with and directly supervise an RN or a LPN who will provide ongoing supervision of all personal assistants. However, only a RN is authorized to conduct the initial assessment and subsequent reassessments.

   b. The supervising RN or LPN must be currently licensed to practice nursing in the Commonwealth and have at least 2 years of related clinical nursing experience which may include work in an acute care hospital, public health clinic, home health agency, ICF/MR or nursing facility.

   c. Employ and directly supervise personal care aides who will provide direct care to individuals. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by the DMAS. Each aide must:

      (1) Be able to read and write English to the degree necessary to perform the tasks expected;

(2) Prior to assigning an aide to an individual, the provider agency must obtain documentation that the aide has satisfactorily completed a training curriculum consistent with DMAS requirements. The DMAS requirements may be met in one of three ways:

a. Registration as a Certified Nurse Aide;

b. Graduation from an approved educational curriculum which offers certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Aide; or

c. Completion of provider-offered training, which is consistent with the basic course outline found in the "Exhibits" at the end of this chapter and subject to prior approval from DMAS;

(3) Be physically able to do the work;

(4) Have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children;

(5) Have a criminal record check.

Providers must also assure and document that persons providing Personal Care services have received training in the characteristics of developmental disabilities and appropriate interventions, training strategies, and other methods of supporting individuals with functional limitations.

Personal Care service providers may be related to the waiver recipient, but may not be the parent of a minor child receiving services, the individual's spouse, or legally responsible relatives of the individual. Payment may not be made for services furnished by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who provide Personal Assistance services must meet the same standards as providers who are unrelated to the waiver recipient.

Respite Care: Agency-Directed

Providers must have a current DMAS Participation Agreement to provide Respite Care services. Agencies that have a DMAS Participation Agreement to provide Respite services may provide DD Waiver Respite Care under this agreement. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

DMAS will not contract directly with individuals to provide Respite Care. Private agencies and providers may employ individuals to provide Respite Care, but must then have a provider agreement with DMAS to provide Respite Care and bill for the services provided by those individuals.

Respite Care providers may be related to the waiver recipient, but may not be members of the immediate family, which is defined as parents of minor children, spouses or legally responsible relatives for the individuals. Payments may not be made to other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide Respite Care must meet the same standards as providers who are unrelated to the individual.

The following types of providers can provide Respite Care:

1. A Personal Care/Respite Care agency currently enrolled with DMAS to provide Respite Care services may provide DD Waiver Respite Care services based in the home of the individual.

2. Individuals who provide care must meet the requirements of DMAS Personal/Respite Care Aide. Basic qualifications for Personal/Respite Care Aides include:

    - Physical ability to do the work;
    - Ability to read and write in English; and
    - Completion of a 40-hour training curriculum consistent with DMAS requirements. Prior to assigning an aide to an individual, the provider agency must obtain documentation that the aide has satisfactorily completed the 40-hour training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:

        (a) Registration as a Certified Nurse Aide;

        (b) Graduation from an approved educational curriculum which offers certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Aide;

        (c) Provider-offered training, which is consistent with the basic course outline found in the "Exhibits" at the end of this chapter and subject to prior approval from DMAS;

        (d) As defined in 12 VAC35-102-10, an agency licensed by DMHMRSAS as a provider of:

            1) Supportive Residential services which may provide Respite Care services based in and from the individual's home;

            2) Center-Based Respite which may provide Respite Care services based in and from Medicaid-enrolled community-based providers and Intermediate Care Facilities for the Mentally Retarded;

3) In-Home Respite, which may provide Respite Care services based in and from the individual's home.

(e) Criminal Record Check.

3. Individuals who are registered with an organization licensed by DMHMRSAS to provide respite care services must be recruited, trained, and supervised by the RN at the provider agency or the organizations staff. If the provider is a DMAS enrolled Personal Care/Respite Care, agency (does not apply to DMHMRSAS or DSS licensed or approved agencies), the respite care provider must employ or subcontract with and directly supervise a RN or a LPN who will provide ongoing supervision of all respite care assistants:

   a. The RN or LPN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

   b. Based on continuing evaluations of the assistant's performance and individual's needs, the RN or LPN supervisor shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated. Providers shall have a satisfactory work record, as evidenced by two references from prior job experience, including no evidence of abuse or neglect of incompetent or incapacitated individuals.

Foster Care providers are eligible to receive respite care as they are not considered paid caregivers. Treatment foster care providers are not eligible to receive respite care.

Absence/Substitution of Aides

When a respite care aide is absent and the respite care provider agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to individuals.

If a provider agency cannot supply a respite care aide to render authorized services, the agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the individual's care to another agency.

During temporary, short-term lapses in coverage, not to exceed two weeks in duration, a substitute aide may be secured from another respite care provider agency or other home care agency. Under these circumstances, the following requirements shall apply:

- The respite care agency having individual responsibility shall be responsible for providing the RN or LPN supervision for the substitute aide.

- The agency providing the substitute aide shall send a copy of the aide's daily records signed by the individual, and the substitute aide to the respite care agency having individual care responsibility. All documentation of services rendered by the

substitute aide shall be in the individual's record. The documentation of the substitute aide's qualifications shall also be obtained and recorded in the personnel files of the agency having individual care responsibility. The two agencies involved shall negotiate the financial arrangements of paying the substitute aide.

- The provider agency having individual responsibility shall bill DMAS for services rendered by the substitute aide.

Substitute aides obtained from other agencies may be used only in cases where no other arrangements can be made for individual respite care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case shall be transferred to another respite care provider agency that has the aide capability to serve the individual or individuals.

Skilled Nursing Services

Providers must have a current DMAS Participation Agreement to provide skilled nursing services. The agency designated in the Participation Agreement is the responsible provider and must bill DMAS for Medicaid reimbursement.

The following types of providers can provide Nursing services:

1. A provider enrolled with DMAS as a Private Duty Nursing or Home Health provider agency; or

2. A Registered Nurse or Licensed Practical Nurse, under the supervision of a Registered Nurse, licensed by the Commonwealth of Virginia and contracted or employed by a DMHMRSAS licensed Respite Care, Day Support or Residential Support providers.

The provider may employ individuals who meet the requirements to provide Nursing services, but the provider must then have a provider agreement with DMAS to provide DD Waiver Nursing services and bill for the services provided by those individuals. Skilled Nursing services may be provided by persons related to the waiver recipient, but may not be members of the immediate family, which is defined as parents of minor children, spouses or legally responsible relatives for the individuals. Payments may not be made to other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide Nursing services must meet the same standards as providers who are unrelated to the individual. A Foster Care provider may not be the skilled nursing services provider for the same persons to whom they provide Foster Care.

Environmental Modifications

Providers must have a current DMAS Participation Agreement to provide Environmental Modifications as a Durable Medical Equipment provider. DMAS will permit only a provider to bill for Medicaid reimbursement for Environmental Modifications provided by individuals or companies contracted by the provider to make the necessary modifications.

The contractor must:

1. Comply with all applicable state and local building codes;

2. If used previously by the provider, have satisfactorily completed previous environmental modifications; and

3. Be available for any service or repair of the environmental modifications.

As described in Chapter IV, it is possible that the services of any or all of the following four professions may be required to complete one modification:

1. A Rehabilitation Engineer;

2. A Certified Rehabilitation Specialist;

3. A building contractor; or

4. A vendor who supplies the necessary materials.

Assistive Technology

A provider may either expand its current DMAS Participation Agreement to provide Assistive Technology or obtain a Durable Medical Equipment (DME) provider agreement with DMAS. Only a DME provider may bill for this service.

DMAS contracts directly with DME providers, which routinely provide specialized medical equipment and supplies in accordance with the Virginia *State Plan for Medical Assistance*. Equipment or supplies not covered by the *State Plan* may be requested under DD Waiver Assistive Technology.

Crisis Stabilization

Providers must have a current DMAS Participation Agreement to provide Crisis Stabilization for clinical services or Crisis Supervision for direct supervision services. The agency or individual designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

A Crisis Stabilization service provider must be licensed by DMHMRSAS as a provider of Outpatient services, Residential services, Supportive Residential services, or Day Support services to provide Clinical or Behavioral Intervention. In addition to meeting the above licensing requirements, the provider agency must employ or use qualified personnel or licensed mental health professionals to provide clinical or behavioral interventions. These interventions might include crisis counseling, behavioral consultation, or related activities to individuals with developmental disabilities who are experiencing serious psychiatric or behavioral problems. The face-to-face assessment or reassessment required to initiate or continue this service must be conducted by a qualified developmental disabilities professional.

The qualified developmental disabilities professional must have:

1. At least one year of documented experience working directly with individuals who have related conditions; and either

2. A doctor of medicine or osteopathy or a registered nurse; or

3. A bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology.

To provide the Crisis Supervision component, agencies must be licensed by DMHMRSAS as providers of Residential, Supportive Residential services or Day Support services.

Consumer-Directed (CD) Services Facilitation

Service Facilitators must have a current DMAS Participation Agreement to provide CD Services facilitation services. To be enrolled as a Medicaid CD Services Facilitator and maintain provider status, the CD Services facilitator shall have sufficient resources to perform the required activities. In addition, the service facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

It is preferred that the Service Facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the Service Facilitator has two years of satisfactory experience in the human services field working with persons with developmental disabilities. The Service Facilitator shall possess a combination of work experience and relevant education, which indicates possession of the following knowledge, skills, and abilities (KSAs). Such knowledge, skills and abilities must be documented on the provider's application form, found in supporting documentation or be observed during the job interview. Observations during an interview must be documented. The KSAs shall include, but not necessarily be limited to:

Knowledge of:

- Types of functional limitations and health problems that are common to different disability types and the aging process as well as strategies to reduce limitations and health problems;

- Physical assistance that may be required by people with severe physical disabilities or elderly persons, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

- Equipment and environmental modifications used and required by individuals with physical and developmental disabilities which reduces the need for human help and improves safety;

- Various long-term care program requirements, including ICF-MR

placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care and respite services;

- IFDDS waiver requirements, as well as the administrative duties for which the individual will be responsible;
- Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;
- Interviewing techniques;
- The individual's right to make decisions about, direct the provisions of, and control his attendant care and consumer-directed respite care services, including hiring, training, managing, approving time sheets, and firing an attendant;
- The principles of human behavior and interpersonal relationships; and
- General principles of record documentation.

Skills in:

- Negotiating with individuals and service providers;
- Observing, recording, and reporting behaviors;
- Identifying, developing, or providing services to persons with developmental disabilities; and
- Identifying services within the established services system to meet the individual's needs.

Ability to:

- Report findings of the assessment or onsite visit, either in writing or an alternative format for persons who have visual impairments;
- Demonstrate a positive regard for individuals and their families;
- Be persistent and remain objective;
- Work independently, performing position duties under general supervision;
- Communicate effectively, verbally and in writing; and
- Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

If the CD Services Facilitator is not an RN, the CD Services Facilitator provider must have RN consulting services available, either by a staffing arrangement or through an agreement. The RN consultant is to be available as needed to consult with individuals/CD services facilitators on issues related to the health needs of the individual. This requirement does not involve an actual visit to the individual, unless needed, and is not meant to replace appropriate physician's office visits.

The CD Services Facilitator may not also be the support coordinator or direct service provider for a given individual. The CD Services Facilitator may not be the individual or the primary caregiver of the individual receiving services.

Attendant Care

For attendant care services, individuals will hire their own personal attendants and manage and supervise the attendants' performance. If an individual has a cognitive impairment or is unable to direct his or her own services, a family caregiver may act on behalf of the individual as the employer.

Personal attendant qualifications include, but shall not be necessarily limited to, the following requirements. The attendant must:

- Be 18 years of age or older;
- Have the required skills to perform attendant care services as specified in the individuals' Plan of Care (POC);
- Possess basic math skills, and be proficient in reading, and writing English to the extent necessary to carry out duties;
- Possess a valid Social Security number;
- Submit to a criminal records check and, if the recipient is a minor, the child protective services registry. The attendant will not be compensated for services provided to the individual if the records check verifies the personal attendant has been convicted of crimes described in the Code of Virginia 12 § 37.1-183.3 or if the personal attendant has a complaint confirmed by the DSS child protective services registry;
- Be willing to attend training at the individual's or family's request (time spent attending such training may be reimbursed through Medicaid billing under this service);
- Understand and agree to comply with the DMAS DD waiver requirements;
- Agree to receive annual tuberculosis (TB) screening, cardiopulmonary resuscitation (CPR) training and, as appropriate, an annual flu immunization; and

- Be willing to register in a personal attendant registry that will be maintained by the CD Service Facilitator chosen by the individual or individual's family caregiver.

Personal Attendants shall not be spouses, parents of minor children, or legally responsible relatives for the individuals. Payment will not be made for services furnished by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide attendant services must meet the same standards as providers who are unrelated to the individual.

Respite Care: Consumer-Directed

For Consumer-Directed Respite Care Services, individuals will hire their own attendants and manage and supervise the attendants' performance. If an individual has a cognitive impairment or is unable to direct his or her own services, a family caregiver may act on his or her behalf.

Respite care provider qualifications include but shall not be necessarily limited to the following requirements. The attendant must:

- Be 18 years of age or older;
- Have the required skills to perform respite care services as specified in the individual's POC;
- Possess basic math, reading, and writing skills to the extent necessary to carry out duties;
- Possess a valid Social Security number;
- Submit to a criminal records check and, if the recipient is a minor, the child protective services registry. The respite care provider will not be compensated for services provided to the individual if the records check verifies that he or she has been convicted of crimes described in the Code of Virginia § 37.1-183.3 or if the respite care provider has a complaint confirmed by the DSS child protective services registry;
- Be willing to attend training at the individual's or family's request (time spent attending such training may be reimbursed through Medicaid billing under this service);
- Understand and agree to comply with the DMAS DD Waiver requirements;
- Receive annual tuberculosis (TB) screening, cardiopulmonary resuscitation (CPR) training and, as appropriate, an annual flu immunization; and
- Be willing to register in a personal attendant registry that will be maintained by the CD Services Facilitator chosen by the individual or individual's family caregiver.

Respite Care providers may not be the parents of minor children, the individual' spouses, or legally responsible relatives for the individuals. Payment may not be made for services furnished by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide CD Respite Care services must meet the same standards as providers who are unrelated to the individual.

Family and Caregiver Training

A provider must have a current DMAS Participation Agreement to provide Family and Caregiver Training. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Individuals who provide Family and Caregiver Training must have the appropriate licensure or certification as required for the specific professional field associated with the training area, and have demonstrated experience or knowledge of the training topic. Professionals approved to provide Family and Caregiver Training include Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Physicians, Licensed Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, Nurse Aides, Physical Therapists, Occupational Therapists, Speech/Language Pathologists, Licensed Teachers.

Individuals must work for an agency or organization that has a provider agreement with DMAS to provide Family and Caregiver Training or be eligible to individually enroll with Medicaid as a provider of this service. Organizations eligible to participate include home health agencies, community developmental disabilities agencies, developmental disabilities residential providers, community mental health centers, and public health agencies, hospitals, clinics, and in-home rehabilitation agencies. All providers must have the applicable license or certification for their area of expertise.

Personal Emergency Response System (PERS)

Providers must have a current DMAS Participation Agreement to provide PERS services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

A PERS provider must be a certified home health or personal care provider, a durable medical equipment provider, a hospital or a PERS manufacturer that has the ability to provide PERS equipment, direct services, i.e. installation, equipment maintenance and service calls, and PERS monitoring.

The PERS provider must provide an emergency response center staff with fully trained operators that are capable of receiving signals for help from a individual's PERS equipment 24-hours a day, 365, or 366 as appropriate, days per year; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the individual needs emergency help.

A PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

The PERS provider shall have the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices or medication-monitoring unit while the original equipment is being repaired.

Adult Companion Care

A provider must have a current DMAS Participation Agreement to provide Adult Companion Care. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The following types of providers can deliver Adult Companion care services:

1. Licensed by DMHMRSAS as a provider of Residential Services, Supportive Residential Services, Day Support or Respite services; or

2. DMAS enrolled Personal Care/Respite Care provider agency.

Agencies that provide Adult Companion Care Services must employ individuals to provide companion care who meet the following requirements:

- Be at least 18 years of age;
- Possess the ability to read and write in English (to the degree necessary to perform the tasks expected) and basic math skills;
- Be capable of following a plan of care with minimal supervision;
- Submit to criminal history record check. The companion will not be compensated for services provided to the individual if the records check verifies the companion has been convicted of crimes described in § 37.1 – 183.3 of the *Code of Virginia*;
- Possess a valid Social Security number; and
- Be capable of aiding in the activities of daily living or instrumental activities of daily living.

Companions must be employees of agencies that contract with DMAS to provide Adult Companion Care Services. Agencies are required to have a qualified companion care supervisor to monitor Adult Companion Care Services. The supervisor must have a bachelor's degree in the human services field and at least one year of experience working in the developmental disabilities field, or be a certified Home Health Aide, an LPN, or an RN with a current license or certification to practice in the Commonwealth.

Companions cannot be spouses, parents of minor children, or legally responsible relatives for the individuals. Payment will not be made for services furnished by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide Companion Services must meet the same standards as providers who are unrelated to the individual.

**REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT**

Section 504 of the Rehabilitation Act, as amended (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in his or her program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

**UTILIZATION OF INSURANCE BENEFITS**

The Virginia Medical Assistance Program is the payor of last resort with the exception of Part C of the Individuals with Disabilities Education Act. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third party payers. Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare) -** Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- **Workers' Compensation -** No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.

- **Other Health Insurance -** When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but no payment will be made by Medicaid if the combined total payment from all insurance exceeds the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries -** DMAS will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Code of Virginia § 8.01-66.9. In liability cases, providers may choose to bill the

third-party carrier or file a lien in lieu of billing Medicaid.

- In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 to:

  Third Party Liability Casualty Unit
  Virginia Medical Assistance Program
  600 East Broad Street
  Richmond, Virginia 23219

(See "Exhibits" at the end of this chapter for a sample of this form and at the end of Chapter V for information on how to order the DMAS-1000.)

## TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and FH-PEU thirty (30) days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

## TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

## RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process consists of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have a 30 day notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 2.2-4000 et seq. of the Code of Virginia) (the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action, which includes termination or suspension of the provider agreement, and denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services, which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process consists of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with

applicable law and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

## REPAYMENT OF IDENTIFIED OVERPAYMENTS

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to the Code of Virginia, § 32.1-313.1. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

## MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are a member of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the FIRST HEALTH - Provider Enrollment Unit at the address given under "Requests for Participation" earlier in this chapter.

# EXHIBITS

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Entity Name _____

**HOME AND COMMUNITY-BASED CARE APPLICATION for PROVIDER STATUS as a SUPPORT COORDINATION PROVIDER**

Name your entity will do business as: _____

**PART A. PREVIOUS PROVIDER EXPERIENCE**

**1. Type of Related Experience:**

I request to be approved as a provider of Support Coordination Services.
My agency is currently a Virginia Medicaid-enrolled provider.

**Yes ☐** **No ☐**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

**2. Please type or print the Administrator's Name:**

_____

**PART B. GENERAL INFORMATION**

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help DMAS identify information you send to us, and direct where to send the provider information. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

**ADMINISTRATIVE SUPPORT COORDINATION PERSONNEL** ***(Fill in all that apply.)***

| _____ | _____ | _____ |
|---|---|---|
| Provider responsible for signing contract | Title | Phone number |

☐ This Support Coordination provider is responsible for general management of requested Medicaid program(s)

Reports to: _____

| _____ | _____ | _____ |
|---|---|---|
| Chief Administrator On Site | Title | Phone number |

☐ This Support Coordination provider is responsible for general management of requested Medicaid program(s)

Reports to: _____

| _____ | _____ | _____ |
|---|---|---|
| Other On-site Contact Support Coordinator | Title | Phone number |

☐ This Support Coordination provider is responsible for general management of requested Medicaid program(s)

Reports to: _____

| _____ | _____ | _____ |
|---|---|---|
| Chief Corporate Officer | Title | Phone number |
| _____ | _____ | _____ |
| Other Corporate Contact | Title | Phone number |

**GEOGRAPHICAL AREAS TO BE SERVED (*See Chapter II for policy re: allowable service area)***

List Cities/Counties in which you intend to serve Medicaid DD Waiver-eligible recipients.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3) list the board members.**

| LEGAL NAME | ADDRESS | % |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS**

Federal requirements stipulate that any Support Coordination provider listed above with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

**CHECK ONE: ____ N/A ____ APPLICABLE, COMPLETE THIS SECTION**

| NAME | AGENCY NAME | TYPE OF BUSINESS |
|---|---|---|
| | | |
| | | |
| | | |

**TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)**

| Non-Profit | Proprietary | State or Local Government |
|---|---|---|
| ____ Church Related | ____ Single Proprietorship | ____ State |
| ____ Non-Profit Corporation | ____ Partnership | ____ County/City |
| ____ Other Non-Profit Ownership | ____ Corporation | ____ Hospital (District Authority) |
| | ____ Hospital/Nursing Facility | |

**REQUIREMENTS AND SIGNATURE**

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any Support Coordination on (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes ☐ No ☐**.

If yes, explain the type of offense, name and title of individual:

_____

_____

**The signature below certifies the following:**

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of Support Coordination on signing application Print title

_____ _____
Signature of Support Coordination on signing contract Date

## PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

***COMPLETE FOR SUPPORT COORDINATION***

***You are responsible for assuring that SUPPORT COORDINATION staff meet the following qualifications. It is the provider's responsibility to assure that any new professional staff are oriented to the service and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all staff who provide services of the requirements related to the performance of their duties.***

***The entity may directly provide Support Coordination services and/or may contract with private entities. If services are contracted, the agency/organization/individual remains the responsible provider and only the agency/organization/individual may bill DMAS for Medicaid reimbursement.***

***The provider must operate a 24-hour emergency services system and guarantee that recipients have access to emergency services.***

***An employee of a contract agency, who provides Support Coordination services, must possess a combination of developmental disability work experience and relevant education which indicates that he or she has the knowledge, skills, and abilities (KSAs), as established by DMAS, necessary to perform support coordination services billable under Medicaid.***

***The Director of the contract agency will certify via letter to the DMAS, that the individuals who will provide Support Coordination services in that catchment area meet the required KSAs. Individuals who do not demonstrate or possess the required KSAs cannot provide Support Coordination services for which Medicaid reimbursement is received.***

***A SUPPORT COORDINATION provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.***

**1. List below the individual who will be responsible for daily management of the Support Coordination and who they report to:**

| Name | Title | Phone Number |
|---|---|---|
| Reports to: _____ | | Phone Number |

| Name | Title | Phone Number |
|---|---|---|
| Reports to: _____ | | Phone Number |

Entity Name_____

**HOME AND COMMUNITY-BASED CARE APPLICATION for PROVIDER STATUS as a PERSONAL EMERGENCY RESPONSE PROVIDER**

Name your entity will do business as: _____

**PART A. PREVIOUS PROVIDER EXPERIENCE**

**2. Type of Related Experience:**

I request to be approved as a provider of Personal Emergency Response Services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Durable Medical Equipment or Personal Care.

**Yes ☐ No ☐**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

**3. Please type or print the Administrator's Name:**

_____

Entity Name_____

**PART B. GENERAL INFORMATION**

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

**ADMINISTRATIVE PERSONNEL** ***(Fill in all that apply.)***

| _____ | _____ | _____ |
|---|---|---|
| Person responsible for signing contract | Title | Phone number |

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

| _____ | _____ | _____ |
|---|---|---|
| Chief Administrator On-site | Title | Phone number |

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

| _____ | _____ | _____ |
|---|---|---|
| Other On-site Contact Person | Title | Phone number |

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

| _____ | _____ | _____ |
|---|---|---|
| Chief Corporate Officer | Title | Phone number |
| _____ | _____ | _____ |
| Other Corporate Contact Person | Title | Phone number |

**GEOGRAPHICAL AREAS TO BE SERVED (*See Chapter II for policy re: allowable service area)***

List Cities/Counties in which you intend to serve Medicaid DD Waiver-eligible recipients.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Entity Name_____

**OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3) list the board members.**

| LEGAL NAME | ADDRESS | % |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS**

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

**CHECK ONE: ____ N/A ____ APPLICABLE, COMPLETE THIS SECTION**

| NAME | AGENCY NAME | TYPE OF BUSINESS |
|---|---|---|
| | | |
| | | |
| | | |

**TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)**

| Non-Profit | Proprietary | State or Local Government |
|---|---|---|
| ____ Church Related | ____ Single Proprietorship | ____ State |
| ____ Non-Profit Corporation | ____ Partnership | ____ County/City |
| ____ Other Non-Profit Ownership | ____ Corporation | ____ Hospital (District Authority) |
| | ____ Hospital/Nursing Facility | |

**CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:**

☐ Durable Medical Equipment ☐ Home Health ☐ Social Work Services ☐ Hospice
☐ Rehabilitation Services ☐ Case Management ☐ Others _____

Entity Name_____

**REQUIREMENTS AND SIGNATURE**

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes ☐ No ☐**.

If yes, explain the type of offense, name and title of individual:

_____

_____

**The signature below certifies the following:**

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____

Print Name of person signing application Print title

_____ _____

Signature of person signing contract Date

Entity Name_____

**PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS**

***COMPLETE FOR PERSONAL EMERGENCY RESPONSE***

***You are responsible for assuring that PERS staff meet the following qualifications. A PERS provider must be a certified home health or personal care agency, a durable medical equipment provider, a hospital or a PERS manufacturer that has the ability to provide PERS equipment, direct services, i.e. installation, equipment maintenance and service calls, and PERS monitoring. It is the provider's responsibility to assure that any new professional staff are oriented to the service and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all staff who provide services of the requirements related to the performance of their duties.***

***The PERS provider must employ an emergency response center staff with fully trained operators that are capable of receiving signals for help from a recipient's PERS equipment 24-hours a day, 365, or 366 as appropriate, days per year to determine whether an emergency exists; and notify an emergency response organization or an emergency responder that the PERS recipient needs emergency help.***

***A PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.***

***Standards for PERS Equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.***

**1. List below the person who will be responsible for daily management of the Personal Emergency Response System and who they report to:**

| Name | Title | Phone Number |
|---|---|---|
| Reports to: | | Phone Number |

| Name | Title | Phone Number |
|---|---|---|
| Reports to: | | Phone Number |

**DO NOT WRITE IN SHADED AREAS. DO NOT ADD CONDITIONS TO THE AGREEMENT. WE DO NOT ACCEPT AGREEMENTS VIA FAX OR AGREEMENTS ON THERMAL PAPER.**

**Commonwealth of Virginia**
**Department of Medical Assistance Services**
**Medical Assistance Program**
**Mental Health & Mental Retardation & Substance Abuse Services & Developmental Disability Participation Agreement**

If re-enrolling enter Medicaid Provider Number here _____

☐ CSB Provider ☐ Private Provider

**This is to certify:** **PAYMENT/CORRESPONDENCE ADDRESS** **PHYSICAL ADDRESS** (***REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS***)

NAME

ATTENTION

ADDR LINE 1

ADDR LINE 2

CITY, STATE, ZIP

**on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.**

1. **The provider is currently licensed and certified under applicable laws of the state as of _____and has been fully certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services to provide the services checked below and assures that those individuals providing the services meet the criteria of this certification.**

**MH/MR SA Services**

| | |
|---|---|
| | **Intensive In-Home** |
| | **Day Treatment for Children/Adolescents** |
| | **Day Treatment Partial Hospitalization** |
| | **Psychosocial Rehabilitation** |
| | **Crisis Intervention** |
| | **MH Case Management-CSBs ONLY** |
| | **MR Case Management-CSBs ONLY** |
| | **Intensive Community Treatment** |
| | **Crisis Stabilization** |
| | **Support Services** |
| | **Day Treatment for Pregnant Women** |
| | **Res. Treatment for Pregnant Women** |

**MR Waiver Services**

| | |
|---|---|
| | **Nursing Services** |
| | **Day Support** |
| | **Assistive Technology** |
| | **Respite Care** |
| | **Crisis Supervision** |
| | **Therapeutic Consultation** |
| | **Environmental Modification** |
| | **Supported Employment** |
| | **Personal Assistance** |
| | **Crisis Stabilization** |
| | **Residential Support** |

**DD Waiver Services**

| | |
|---|---|
| | Adult Companion Care |
| | Attendant Care |
| | Consumer Directed Respite |
| | Support Coordination |
| | Personal Emergency Response System |
| | In-Home Residential Support |
| | Family and Caregiver Training |
| | Crisis Stabilization |
| | Environmental Modifications |

2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. §794,) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in VMAP.**

3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under VMAP constitutes full payment on behalf of the recipient except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a VMAP recipient for any service provided under VMAP is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider shall reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

***For Provider of Services:***

**For First Health's use *only***

Director, Division of Program Operations Date

**Original Signature of Administrator** **Date**

**Title**

**_____City OR _____County of**

IRS Name (required)

**IRS Identification Number** **(Area Code) Telephone Number**

mail completed agreement to: **one original**

**First Health - VMAP-Provider Enrollment Unit**
**PO Box 26803**
Richmond, Virginia 23261-6803

**Medicare Carrier and Vendor Number (if applicable)**

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

# MAILING SUSPENSION REQUEST

Medicaid Provider Number: _____

Provider Name: _____

I do not wish to receive Medicaid memos, forms or manual updates under the Medicaid provider number given above because the information is available to me under Medicaid provider number

| |
|---|
| |

Provider Signature: _____

Date: _____

Please return this completed form to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803

**DMAS REQUIRED PERSONAL CARE AIDE TRAINING**

**COURSE OUTLINE**

I. The Agency, the Provider, and the Community

A. Introduction to the Agency

1. Structure of organization
2. Overall programs of the agency
3. Agency policies and procedures (e.g., payroll, record keeping, travel and meal expenses, requirements of dress, confidentiality, ethics)

B. Introduction to Personal/Respite Care Services

1. Definition and objectives of the services
2. The team approach to provision of services
   a. Personnel involved (e.g., supervisor, client, physician)
   b. Roles and relationships of personnel involved
3. Role of aide in the provision of services

C. Introduction to the Community

1. Community resources available
2. Relationship to other agencies

II. Persons with Developmental Disabilities

A. Physical and Psychological Aspects of Developmental Disabilities

B. Physical and Emotional Needs of Persons with Developmental Disabilities

C. Types of Common Health Problems

D. Types of Situations in Which the Personal/Respite Care Aide May Be Involved

E. Physical Factors of Special Importance to persons with Developmental Disabilities

F. Concepts of Work and Persons with Developmental Disabilities

III. The Developmentally Disabled

A. Effects of Illness on the Family

1. Financial

2. Psychological

3. Behavioral

B. Effects of Chronic Illness on the Way an Individual Feels About Himself or Herself

C. Individual Reactions to Illness

1. Between family

2. Between individuals

D. Orientation to Types of Developmental Disabilities Which May Be Encountered

1. Autism

2. Cerebral Palsy and Epilepsy

3. Traumatic Brain Injuries

IV. Personal Care and Rehabilitative Services

A. Body Mechanics

1. Importance of body mechanics to the personal care aide and client

2. Limitations on the personal care aide to activities

3. Techniques of body mechanics

a. Helping the client sit up in bed

b. Moving the client in bed

c. Helping the client move from:

1. Bed to chair and return
2. Bed to wheelchair and return
3. Bed to toilet or commode and return
4. Bed to tub or shower and return
5. Chair to commode and return
6. Chair to tub and return
7. Wheelchair to tub and return
8. Wheelchair to commode and return

d. Helping the client walk with walker, crutches, and cane

B. Personal/Respite Care

1. Importance of personal/respite care activities to the client

2. Limitations on the personal/respite care aide's activities

a. Importance of understanding

b. Policies and procedures regarding requests for unauthorized activities

3. Techniques of personal care

a. Assisting the client with eating

b. Assisting the client with dressing

c. Mouth care

d. Hair care

e. Shaving male patients

f. Fingernail care, toenail care

g. Bathing, tub, shower, bed

h. Bed-making with and without the patient in bed

i. Elimination

j. Back rub

V. Home Management

A. Care of the Home and Personal Belongings

1. Importance of maintaining a clean environment

2. Preparation of housekeeping tasks

a. Scheduling of tasks

b. Types of cleaning and laundry supplies

c. Organization of supplies and equipment

d. Use of proper body mechanics

3. Routine care and use of:

a. Cleaning equipment

b. Laundry equipment

c. Kitchen equipment

4. Emergencies related to:

a. Heating equipment

b. Water supply

c. Electricity

5. Care of furniture
6. Repair of clothing and linen
7. Pest control
8. Care of an individual's environment

VI. Safety and Accident Prevention in the Home

A. Common Types of Accidents

B. Accident Prevention

1. Typical hazards in the home
    a. Bathroom
    b. Kitchen
    c. Stairway
    d. General
2. Ways to safety-proof the home

C. Policies and Procedures Regarding Accidents or Injuries in the Home to Self and Client

1. Limitations of the aide
2. Techniques of simple first aid
    a. Treatment of abrasion
    b. Treatment of abrasions, cuts, bruises
    c. Treatment of first and second degree burns
    d. Poisoning
3. Medical and fire emergencies

VII. Food, Nutrition, and Meal Preparation

A. Importance of Nutrition to the Individual

B. General Concept of Planning Meals

1. Nutritional value
2. Cultural and ethnic food patterns
3. Individual likes and dislikes
4. Budgetary limitations

C. Special Considerations of Normal Diet:

    1. Persons with Developmental Disabilities

    2. Persons with Developmental Disabilities who are ill

D. Special Considerations in Preparation of Special Diets

    1. Importance of special diets

    2. Common types of special diets

    3. Policy and procedure regarding the aide's activities in relation to special diets

E. Food Purchasing and Preparation

    1. Buying guides

    2. Techniques of food preparation

F. Food Storage and Sanitation

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

# THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

_____

_____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87